

*Demographic Dynamic of war refugees and  
displaced population: Angola (1999/2000)*

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## **Demographic Dynamic of war refugees and displaced population: Angola (1999/2000)**

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### **Introduction**

This article is a by–product of the technical and financial support that the United Nations Fund for Population Activities (UNFPA) gives to Angola. The country, located in the Middle Africa, is experiencing at current times, huge growth of displaced people as a consequence of war during the last 25years by now. During the last years, the number of displaced population has reached frighten figures as the Angolan government, as well as some humanitarian organisations, estimate they are about 4 million <sup>1</sup>.

They are focus of great concern for local, national and international authorities, since their lif conditions become more and more miserable. Thus, upon request of the Angolan government, UNFPA developed a project between 1999 and 2000, aiming to evaluate life conditions of families and reproductive health of the displaced in areas with important flows and in process of intensification.

The project, named "Reproductive Health and Family Survey among the displaced population" (RHFS), that included quantitative and qualitative data collection was applied to Huila, Benguela, Malange and Zaire, provinces that gather the largest flows of displace population. (See Map 1).

The study uses data from the referred project, and aims to evaluate the demographic profile of the displaced population in Angola<sup>2</sup>. Firstly, an overview of the Angolan context as part of Sub–Saharan Africa, particularly, related to demographic responses to acute situations is presented. Then, the demographic dynamics of the displaced of war is made through the analyses of the three variables, migration, fertility and mortality. Emphasis is given to th reproductive process and some of the main determinants.

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The authors are grateful to UNFPA/Angola for permitting the use of the data collected for the "Reproductive Health and Family Survey" project in the provinces of Huila, Benguela, Malange and Zaire.

<sup>1</sup> A UTCAH (Technique Unit for Coordination of Humanitarian Aid - Angola) estimates about 1,5 million of ‘antique’ displaced and about 2,3 millions of ‘new’ displaced in Angola at the end of 2000. Unofficial sources suggest that displaced people increased nearly one million over 1999.

<sup>2</sup> This paper takes advantage also of several preliminary reports; among them: UNFPA-Angola, 1999; Madden et. Al., 2000; Ribeiro et al., 2000; UNFPA-Angola, 2001.

Finally, it is the authors’ hope, this report to become important instrument for guiding population policies of spatial re–distribution for the displaced and to attend not just economic, but above all, social and cultural needs of such vulnerable population.

Results also intends to contribute somehow to maximise the always (or chronic) meagre resources destined to woman's health services, particularly those related to reproductive behaviour, thus making possible the implementation of reproductive preferences respecting th couples condition of human beings.

**Map 1. Angola and provinces – circa 2000.**



## **1. Background: Africa, Angola, war refugees and the relationships between acute socio–economic crises and their demographic dynamics.**

To raise a family according to inherited values and to be fond of it is a very difficult task when one is poor. Worse than raising a family in the ordinary miserable poverty, however, it is to raise it when one is a miserable war displaced.

The known poverty - largely widespread in Sub–Saharan Africa– is the context of war displaced people, and for a better understanding of its Demographic dynamics, relationships between population and society in acute crisis is briefly described on this item.

From a short overview of available literature, it is widely accepted that –whether or not– the 1980s were a lost decade for the major part of LDC , it was not a healthy time for Africa and th

statistics may prove it <sup>3</sup>. Briefly, public investments diminished greatly, terms of trade were not generally favorable; export performances were poor and large numbers of African states were forced to adopt structural adjustment policies designed to reduce import dependence and government deficits (Becker and Morrison, 1995, p. 139)

The crisis remained through the nineties, since negative economic growth indexes persisted and among the countries facing military strife, Angola is a typical example: the 1998 annual GDP equivalent to US \$ 527,00 per capita, was less than in 1990 and even lower than in 1980 (UNDP, 2000).

Generally speaking, this is the economic background of the African demographic transition that, despite weak signals of change, remains at the nearly stage of high population growth in most of the African countries. Certainly, worsening of life conditions had direct consequences in the family formation, and from the demographic point of view, in the mortality and fertility patterns.

A 1986 study of how well countries had performed in terms of mortality indicators relative to their per capita income shows that the highest mortality levels are, indeed in Sub-Saharan African countries. Among them, sure, *‘the group with interminable civil wars –Angola, Mozambique, and Ethiopia (plus, almost certainly, southern Sudan)’*. The internal military conflict is strongly related to the excessive high mortality levels, *‘not so much because of deaths in warfare but because of the breakdown in government services of all kinds, including health service, the disorganization of the distribution by the market, and the collapse of law and order’*. (Caldwell, 1995. P. 20-21.) Thus, it is war, besides of just poverty, the main reason for the Angolan population to be among those with the highest probabilities of dying before age 5, and also with many women dying from pregnancy-related causes.

Consensus about changes in fertility and severe socio-economic crises –war among them– is less clear. Reproductive behavior in modern times seems to transcend temporary or even long-term crises as a war conflict. On the one side and far from convinced, Lee (1990) tends to the school of thought of fertility decline after/during acute crises. On the other side, a review by McGinn, (2000) does not find common fertility patterns emerging among refugees. The immediacy and severity of emergencies may affect short-term response, but in the long term refugees’ fertility appears to be influenced by social and demographic factors long associated with fertility change.

In the short term fertility levels may increase as a reflect of new negative or positive life conditions that refugee confront. Among the negatives, Kraus *et al.* (2000) mention, that *‘many refugee women and adolescents find that their escape route (from war) is fraught with sexual violence inflicted by border guards, soldiers, the local population or even the fellow refugees. Thousands of refugee women are raped or coerced into sex and often seek unsafe abortions to*

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<sup>3</sup> For example, the average annual rate of growth of real gross national product per capita between 1980 and 1987 was 4,0 per cent for all low-income countries, as classified by the World Bank; for the African countries, however, it was -3,6 percent. (National Academy Press (1993) p. 9.

*terminate the pregnancies that result*’. On the positive side, the better nutritional patterns and less psychological stress for being away from the conflict area would increase fertility level. Thus, sub–fecundity due to extreme poverty of refugee Kmer women in Thailand, for instance, was observed to reverse quickly with improved nutrition.

In any case, Caldwell’s findings in Sub–Saharan Africa from late 80s fit well into the current Angolan reality, and, we believe, into the displaced population. He mentions that the major support for high fertility has been a division between those responsible for fertility decision and those who bear the greater share of the economic burden. *‘In a patrilineal, bridewealth society, reproductive decisions are a matter for the husband and his family of origin* (p. 26). Thus, the less the contact with “modernization”, whatever their meaning, the stronger th attitudes favoring high fertility. This seems the case of the displaced Angolan population.

He also mentions as a factor encouraging high fertility, the traditional religious pronatalism and the horror of barrenness, that, besides, has led to a reluctance to employ sterilization or even such temporary stopping measures as the intrauterine device (IUD). Persistence of high mortality, particularly child and infant mortality due to either, structural or conjunctural reasons (as a civil war) are therefore, linked to high fertility levels in the poorest African context. Angola is among them, and surely the displaced. Considering the horror of childlessness, thus imputation of evil or at least of dangerous ill fortune, are not very different for a childless woman or for one who has borne several only to see them all die. The author says that decline in child mortality will prove to be most decisive factor in determining the onset of fertility transition in Sub–Saharan Africa. Based on evidence from Zimbabwe and Botswana, he believes that fertility may decline once infant mortality reach levels around, perhaps, 70 per thousand. Barbieri (Ordina/IUSSP s/d) that suggests an Infant Mortality threshold of say, 100 per thousand, shares similar rationality.

Finally, the disruption of the demographic dynamics in a context like Angola, as a direct consequence of intensity of military activity in a general way, is briefly described next using some findings by Lindstrom and Berhanu (1999), with regard to marital fertility. Firstly, in th areas of conflict, life destruction wrought by the war itself, boosts up mortality levels. Reproductive behaviour is affected in numerous forms: the psychological stress and the strain of carrying out daily activities in a war zone will reduce the frequency of intercourse. Also, military activities generate refugee flows and occur in conjunction with government resettlement programs, often resulting in the separation of couples for extended periods; similarly during periods of intense military activity, the mobilisation of militia and other military reserves and new conscripts separate couples.

In short, displacements do occur during war times, either because of individual or institutional initiatives. Possibilities of forced recruitment and/or summary execution of suspected rebels and presence of troops in rural areas together with fears of crop confiscation are examples of th former. Besides, massive resettlement programs to shift away from areas of intensive military activity, sponsored by the government or ONGs are in one way or another, implemented.

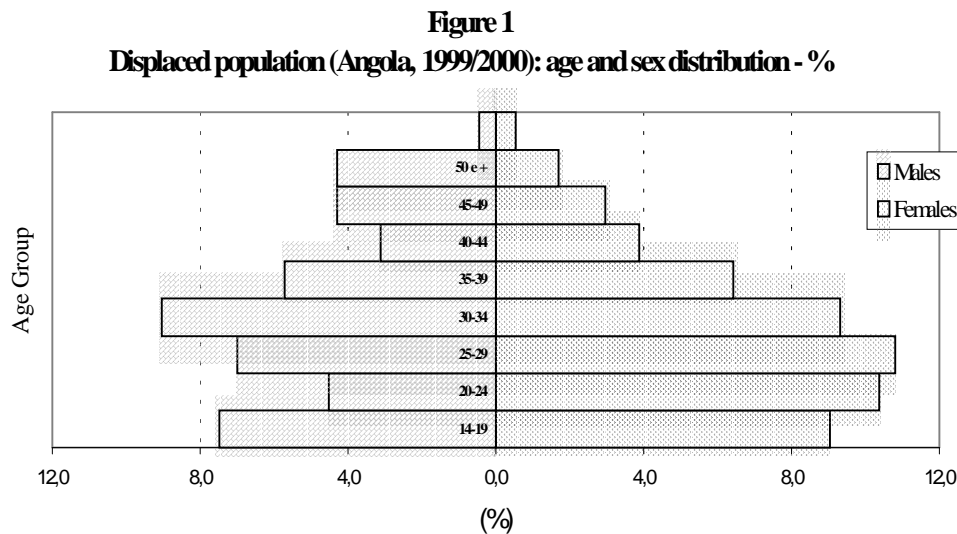
In these circumstances, it is certainly that being displaced is the main determinant of whatever demographic dynamic they undergo.

### 3. About the dataset

Data was collected from a 1,421 sample size of people identified as war displaced. The study defined the displaced as “any person that was forced to migrate as a direct consequence of war from their previous residence (at municipality levels) aged 14 or more”.

The fieldwork had several constrains and difficulties, perhaps more than expected in this sort of survey due to extreme poverty and, particularly to war stress. All evidences, however, lead us to conclude that *“the results (from the sample survey) constitute a reliable portray of th displaced population reality related to their respective provinces (and/or capitals), districts and localities where the survey was done”* (UNFPA, 2001; p. 14)

The distribution according to age and sex of the sample is given in Table A1 (Annex). Figure 1 shows the age distribution with the expected pyramidal form; it can be observed a large concentration at ages 20-34 that represent about 70% of total women. It should keep in mind that highest fertility values correspond to these age groups. The men's relative distribution, disproportionate at central ages, is the direct consequence of the armed conflict.



Source: RHFS, UNFPA-Angola, 1999/2000

For analytical purposes, five-year ages group are used when possible; in order to avoid random variations, however, due to the small number of observations in some cases, population was also

classified in two large age groups: up to 25 years and 25 or more. They are denominated "youngsters" and "adults" respectively.

### **3. Migration flows and war intensity**

Considering that all interviewed is, by definition, an individual forced to migrate and therefore, a displaced, the predominant migration flow is characterised next. The survey included a set of questions that allows description of recent movements, among them: place of birth, previous residence and years from last displacement and place of residence in a given fixed data.

Place of birth at province level is the first and simplest element for roughly drawing migration flows. Since this information alone it is not enough to qualify recent flows by origin and type analysis of time of continuous residence (without interruption) in the Province and in th municipal district of current residence (i.e., the final destination of refugees) is also don

The probable period of fleeing is identified through the analysis of time of residence in th municipal district and province of current residence. The time location of displacements allows us to evaluate effects of the intensity of war in the interviewee's original residence at provinc and municipal levels.

The province of residence of the displaced in both October 1992 and December 1998 is analysed. It is assumed that the peace perspective that appeared with the electoral process of October 1992 and the restart of war in December/1998 provoked huge population displacements on inverse directions. In other words, in the first case, the return of displaced to their original areas and in the second case a new reflux towards the capital of the corresponding provinces and/or medium size cities. Analysis of residence in these two fixed dates, allow us to analyse for each province and municipal district, the increase of displaced population coming from other areas over these two fixed dates.

#### **3. 1. Place of birth of the displaced**

Most of the displaced interviewed are natural from the same province where they are currently living as shown on Figure 2.

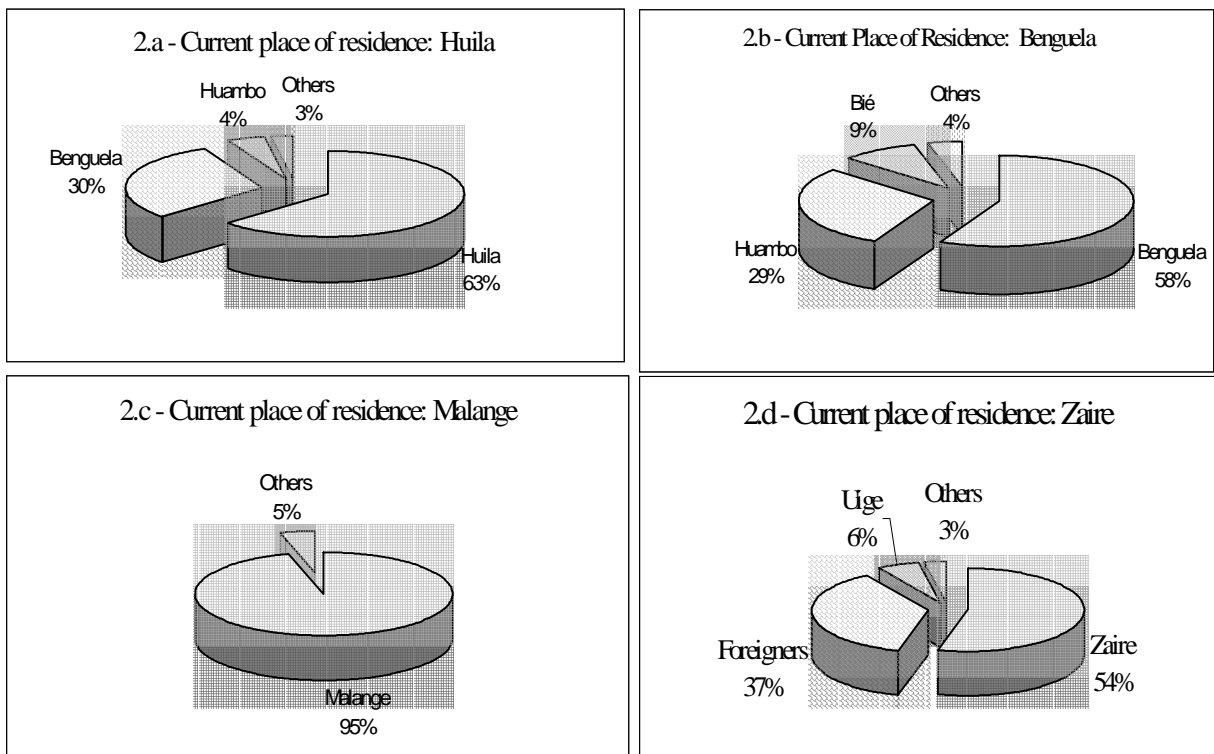
In the case of Malange, 95% of those moved are natural of the same province. The situation of Zaire is different from the other provinces for being a frontier area next to the Democratic Republic of Congo (RDC), thus explaining the large foreigners' presence (37% of the interviewed). It is worth to remember that RDC has been also immersed in a civil war during the last years.

The verification that most of the displaced are native from the current province of residence, led us to infer, that they have as origin other municipal districts of the same province. In other



words, there would be predominantly intra-provincial migration that has as origin the municipal districts in the interior of same province.

**Figure 2**  
**Displaced population (Angola, 1999/2000): Current province of residence according to place of birth**



Source: RHFS, UNFPA-Angola, 1999/2000

### 3. 2. Time of continuous residence in the province and in the municipal district of current residence.

The analysis of period of continuous residence in the province and in the current municipal district allows more precise identification of the inter/intra-provincial migration flows, as well identification of the time location of such migration.

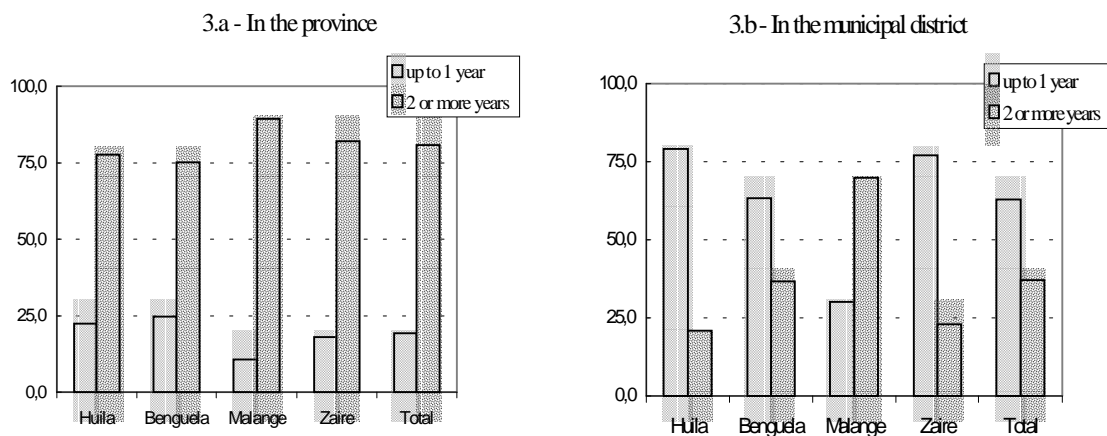
To simplify, analysis of residence is made considering only two periods: up to 1 year and two or more years of residence in the province and in the municipal district. It is worth to remind that this variable is related to two calendar dates since the survey was done in also two different dates. While the interviewed of Huila and Benguela having up to 1 year of residence in th Municipal district made their last movement between June/July 1998 and June/July 1999, those

of Malange and Zaire with the same period of residence made their last movement between November 1999 and November 2000. As one can deduce these were two different moments regarding war intensity in the corresponding provinces. It is probably, for this reason that Malange has the lower proportion of displaced population having up to 1 year of residence. In practice, this would mean that most of the displaced took refuge in this municipal district in 1998/1999 when civil war restarted, having the flow of displaced population stagnated afterwards. It was assumed that once the territories in conflict and dominated areas (by either the government or the *guerrillas*) had their boundaries established, displacements would immediately and quickly decreased.

Four out of five displaced have two or more years of residence in the province (See Figure 3.a). They have on average, 17,7 years of continuous residence (i.e. without leaving the province).

**Figure 3**

**Displaced population (Angola,1999/2000): Period of residence at provincial and municipal district level**



Source: RHFS, UNFPA-Angola, 1999/2000

Malange and Zaire are the provinces with larger proportion of people having two or more years of residence in the province (Figure 3.a), thus corroborating previous findings. At municipal level (Figure 3.b), 71% of the displaced have up to one year of residence in the municipal district; they have on average between 2/3 years of residence in the municipal district. Malange have the municipal districts with larger proportion of displaced having more than one year of residence; it is this province, therefore, that has proportionally more recently displaced

The period of residence in the municipal district according to type of insertion in the community varies. Those living inside the community, which means, in the camps have on average more time living in the municipal district ( 3,3) than those staying outside, living in the peripheral neighbourhoods (1,8 years) do.

In short, the migration flows in the four researched provinces comprise essentially recent displacements (less than one year), they have as origin the same province of birth and th movements are oriented mainly towards medium–size cities and/or capitals. Evidently, these movements are explained by the intensification of the war inside the country.

### 3. 3. Province of residence In October 1992 and December 1998 (Fixed data)

As mentioned, this indicator allows evaluating the increase of displaced population originated from other provinces in a reasonable long period of time (1992 or 1998 until the date of the survey). Data reveals that 80,1% of the interviewed were in the province of current residence in October 1992. In December 1998, the proportion increased up to 91,6%.

The results reveal that between 1992 and 1998 the intra–provincial migration prevailed, corroborating previous analysis by period of residence. Also, during this same period, although at low levels, it would have occurred inter–provincial migration (immigration from other provinces). Recent inter–provincial migration after December 1998 was only 8,4%.

Table 1 shows that most of the displaced people are living in the same province since 1992; significant movements, however, have occurred over the period 1992/98, when 11,5 % of the displaced entered the provinces. Still, 8,4 % of the interviewed had come after 1998. This table is also indicative of the migration flow direction: Benguela has received relatively more displaced people during the last 10 years. Yet, recent migration is also oriented towards this province. The opposite figures corresponds to Malange, where most of the displaced people were living already in this province in 1992.

**Table 1**  
**Proportion of displaced people living in the same**  
**province at the indicated period**

Province	1992	1998	Increment
Total	80.1	91.6	11.5
Huila	77.2	93.4	16.2
Benguela	68.0	86.9	18.9
Malange	94.3	98.0	3.7
Zaire	82.9	89.3	6.4

Source: RHFS, UNFPA-Angola, 1999/2000

This information together with years of residence in the same municipality reveals that migration has been meanly intra–province.

### 3. 4 Municipal district of residence in October 1992 and December 1998

Figures 4 and 5 in Annex trace detailed information at municipal district level about residence at the fixed given data and the current one (Migration Matrixes).

Comparison of both places of residence current and in October 1992, at municipal district level shows that 6% of the interviewed (85 persons), declared that in October 1992 they already lived in the same municipal district of current residence. From these, 43 declared to live in the same municipal district for less than six years, which means that in the period between 1992 and the date of the survey, they left the municipal district and have returned to it later (3% of total). This, although small proportion of return, migration refers to most of the displaced, that after elections in October 1992 –and the subsequent peace signals– would had returned to their original areas. Then they would have gone back in the same condition of refugees to the same municipal districts, due to worsening of the armed conflict in their origin areas. In this sense, these families would have experienced forced displacements for the second time. This re–flow should demand from the corresponding authorities, special attention, because these people will hardly return to their original areas due to the repeatedly negative and frustrated experiences.

Similar conclusions are drawn related to the information on the municipal district of residence in December 1998.

In short, the flows of displaced people due to war conflicts in the provinces of Huila, Benguela, Malange and Zaire are fundamentally intra-provincial and short distance; they go toward medium size cities and capitals: There are signals of moderate inter–provincial flows for the period 1992-1998. In the case of Zaire, being a frontier area, foreigners from RDC are common.

There are also signals of return flows to original areas after the elections and later ebb of those who moved to the municipal districts previously looking for refuge. For these populations, war violence in their origin municipal districts is the fundamental reason that forces them to look for safety in other areas. This search leads them to submit themselves to the lowest poverty level, depending only and exclusively on humanitarian support, always considered, insufficient. In any case, although their vital needs are far from being satisfied, life conditions are relatively better than those beard in their own original (war) areas.

*“Estamos a viver bem, a pessoa não come, mas não escuta mais que estão a correr contigo; embora que estamos a morrer de fome, vamos pedir só a Deus para dar chuva para podermos trabalhar”*

*–We are living okay; people don’t eat, but either listen whatever threatening; although we are starving, we only ask God to give us rain for us to work–*

*(Older woman aged more than 45 years - Fair of Lobito).*

#### **4. The reproductive process**

One of the principal elements of the demographic dynamics of war displaced, is undoubtedly, their reproductive process. This item presents, in the first place, their fertility levels and indicators of the probable trend in the short period.

Socio-economic characteristics are manifestly identified as important determinant of changes in the reproductive patterns. Being the displaced, however, an extremely homogeneous population regarding this characteristics (general extreme poverty, almost universal illiteracy among women, etc.) this aspect is not considered here. Nonetheless for better understanding of the process, the role of some of the denominated "proximate determinants" is explored.

##### **4.1 The high fertility level of the war displaced in Angola**

Available data about the fertility of the displaced population, synthesised in Table 2, show the existence of high fertility levels, with TFR above 11 children per woman. The high value of the mean age of fertility –close to 30 years– reinforces this finding. It is, indeed, a very high level when compared with rates of Middle Africa or even to national averages from countries with similar fragile social development<sup>4</sup>.

Considering the provinces, results indicate that, if current reproductive conditions remain, women would have, on average, more than 10 children in any of the 4 researched provinces.

Despite the eventual random variations were, this is a high and constant fertility situation; which, in any case, we believe, it is very similar the rest of the country<sup>5</sup>.

Regarding coherence of these results, it shall be emphasised, on the one hand, that the methodological considerations about possible over/under registration point out always high fertility levels<sup>6</sup>.

On the other hand, there are several evidences corroborating these high levels. In the first place, the distribution of the ASFR, according to Figure 6 shows a typical pattern of natural fertility, similarly to those of the countries plotted in the same figure. That is, fertility by age is high since the beginning to the end of the reproductive period.

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<sup>4</sup> Countries like Angola, that are at the bottom of the Human Development Index (Burkina Faso Ethiopia, Mali, Niger, Uganda, among them) have a TFR around 7.0 (United Nations, 2001).

<sup>5</sup> Correa (1997) finds for the province of Huambo, another Angolan province, high and constant fertility levels for 1987, without signals of fertility changes in the short term.

<sup>6</sup> Possibilities about period of reference errors and dates of the survey would bring about both under and/or over declaration of CEB. (See, for more details, Ribeiro et al, 2000). Additionally, note that even an analytical adjustment, (dotted line in Figure 6.b) replicates quite well the observed pattern, revealing absence of any voluntary fertility control, i. e. a pattern of natural fertility.

**Table 2**  
**Fertility measures for the total population and according to provinces**

2.a) Total and Provinces: Total Fertility Rate, Parity $P_{(45-49)}$ and Mean Age			
Province	TFR*	$P_{(45-49)}$	Mean Age
<b>Total</b>	<b>11,1</b>	<b>7,3</b>	<b>29,4</b>
Huila	10,8	8,2	30,5
Benguela	11,4	9,1	29,2
Malange	10,0	7,4	27,7
Zaire	11,9	5,9	30,3

2.b) Total population: Age Specific Fertility Rates, Parity and current Fertility (by age)			
Age Group	Specific Rates**	Parity*	Parity estimated from current Fertility***
15 – 19	236,8	0,5	0,6
20 – 24	510,2	2,2	2,7
25 – 29	437,9	3,7	5,1
30 – 34	484,8	5,7	7,4
35 – 39	362,6	6,8	9,5
40 – 44	148,1	6,6	10,7
45 – 49	47,6	<b>7,3</b>	<b>11,1</b>

\* Children per women      \*\* Per thousand      \*\*\* Estimated by applying the Brass method  
Source: Table A2 – Annex. Raw data from: RHFS, UNFPA-Angola, 1999/2000

In the second place, the final parity ( $P_{45-49}$ ), which is the mean number of children ever born that women would have at the end of the reproductive period, is 7.3.

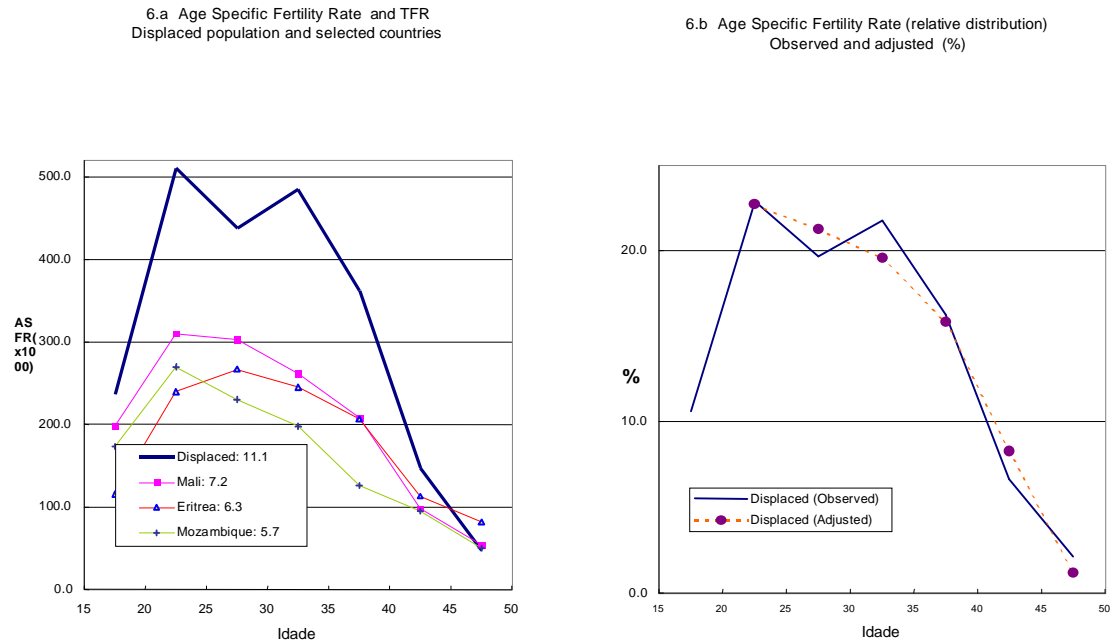
Yet, assuming constant fertility, this population demonstrates high fertility levels even at older ages of the reproductive periods. In other words, after the age 35 –when the most women in the rest of the world, have practically finished their contribution to fertility– in this population it increases in more than 1.6 children (Figure 7.a). This finding is another indicative of the absence of any fertility control.

At more desegregated level, the cases of Benguela and Huila are notable: after the age 35, parity increases in three and two children respectively (Table 3.A in Annex). Figure 7.b shows the provincial levels for  $P_{45-49}$  in decreasing order. The smallest level corresponds to Zaire where women from the oldest age group have  $P_{45-49}$ , equivalent to 6 children. In this province, parity stops increasing from age 35 to 39. This peculiarity warns us, either about the possibility of under-declaration of CEB or about signalling that this province might hold lower fertility levels.

The highest level belongs to the provinces of Huila and Benguela, where women would average by the end of the reproductive period more than 8/9 children respectively (Figure 7.b).

**Figure 6**

**Displaced Population (Angola, 1999/2000): Age Specific Fertility Rate (absolute and relative numbers) and comparison with selected countries**



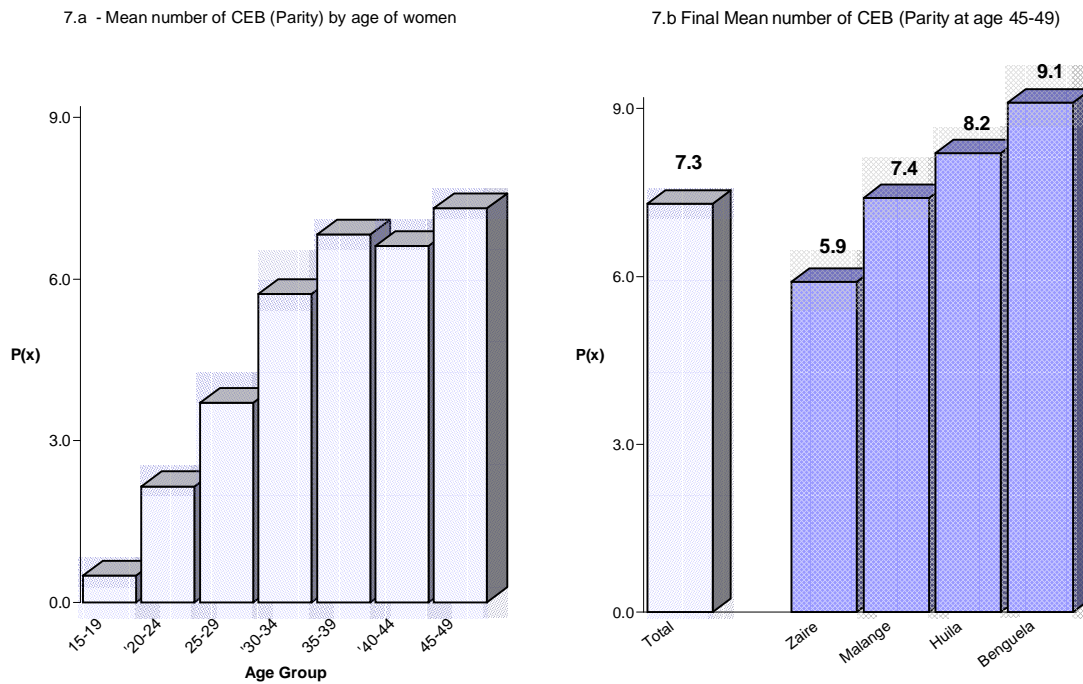
Source: RHFS, UNFPA-Angola, 1999/2000

In the third place, it is considered another type of available information, as, for instance, the pregnant women or male fertility. In the first case, the number of pregnant women at the moment of the survey would equal, if all of them answered correctly, to an annual TFR above 7 (Presuming that all outcomes are live births and an exposure of 9 woman/months). In the case of the male fertility, the level may be indirectly estimated through the number of CEB<sup>7</sup>. For the age group over 25, the average of CEB is about 2,0; being this data similar to the one obtained for women, the extrapolation of this value up to age 50, end up to a mean number above 6. This, again, is an indicative of high fertility levels.

In short, considering that the parity indicates a final mean number of children higher than 7, without strong evidences of error there is a sort of “baby-boon”phenomenon. The extremely high TFR can be interpreted as a recovery of previous levels that were also higher. Figures from Zaire (Table 2.a), would illustrate this situation. The fact that couples did not have conditions for having/conceiving children during the period immediately previous to the displacement, plus high infant and child mortality (that will be seen ahead) configures the propitious scenery for increasing the fertility level.

**Figure 7**

**Displaced Population (Angola, 1999/2000): Mean number of children ever born by age of women and provinces**



Source: RHFS, UNFPA-Angola, 1999/2000

Note that desire of re-populate following a massacre was already used as explanation of sudden increase of fertility in similar situations, for instance among Sudanese refugees (McGinn, 2000). In addition, the study for Lebanon, although with no the clear evidences, wonders if the fertility increase could yet occur, due to the establishment of relative peace, improving economic conditions and the new climate of optimism within Lebanon where pro natality norms remained intact. (Kulczycky and Saxena, 1999)

Finally, the number of pregnant women in the municipal districts, when classified by time of residence would reveal the urgency for replacing children lost or for having the children that were not born in the displacement previous period (Data not shown). Proportionally there are more pregnant among women with less than a year of residence in the municipal district (56%) than the ones having two or more years.

<sup>7</sup> Even though, it shall be remember that among the usual limitations this measure has, the most recurrent is under-estimation of the level.



We may conclude, in any case, that structurally or conjuncturally, both current and recent fertility levels are extremely high.

## **4.2 Perspectives of the fertility level in the short term and the role of some determinants.**

Questions collected in the survey makes possible to evaluate the fertility trends in the short and medium term. Some of them point out elements to support constancy of high fertility levels, as the number of desired children between men and women and to a lesser extent contraception practices. Others, however, signal pressures for shy changes, although still far from onset of fertility decline, they are, for example, abortion and non–planned pregnancies. These questions are considered next.

### **4. 2. 1 Desired children and desired family size**

The survey included some questions about reproductive preferences, such as the desire of becoming pregnant and the number of desired children. The answers were obtained from three subgroups: total of women, pregnant women at the moment of the survey, and total male population.

#### *a) Pregnancy status and Reproductive Preferences among Women*

Regarding the expectancy of becoming pregnant, little more than 50% of women answered that they do intend to become pregnant again, being this expectancy, as expected, higher among young women (59%). Many of them would like to become pregnant within a period of 12 months (40%) and 28% would like to become pregnant after one year. An important proportion falls in the category “the decision is not mine”: 1/3 affirmed that they could not decide by themselves when they should become pregnant. This proportion that can be an indicator of the woman's autonomy and/or of control on her own body, varies between 22% and 54% in the provinces of Malange and Zaire respectively. (Table 3).

Related to reproductive preferences among the pregnant women<sup>8</sup>, most of them want to have more children besides the one to be born (67%). In general, the most wants to have more children and only 3 individuals declare the opposite.

These women would desire, on average, 4,7 more additional children, 70% wants to have at least more than 4 additional children and the expectancy of having more children varies according to the provinces, as shown in Table 4.

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<sup>8</sup> About 15% of women declared to be pregnant, there were no differences by age which is coherent regarding the high fertility levels already mentioned.

**Table 3**  
**Expectancy about getting pregnant and period to do so - by age and provinces**

Province	Total		Expectancy of getting pregnant				Does not want to get pregnant	
			Sub Total	Period				
				Immediately	Next year	After one year		Can not decide
Total	<b>668</b>	<b>347</b>	64	73	97	113	<b>322</b>	
	100.0	51.8	18.4	21,0	28,0	32.6	48.2	
By age								
Up to age 25	242	100.0	59.1	19.2	20,5	27,4	32,9	40.9
25 or more	426	100.0	50.0	17.9	21,4	28,4	32.3	49.4
Provinces								
Huila	131	100.0	45.8	21.7	15,0	35,0	28,3	54.2
Benguela	173	100.0	48.0	25.3	21,7	30,1	22.9	52.0
Malange	172	100.0	58.7	17.8	24,8	35,6	21.8	41.3
Zaire	192	100.0	53.1	11.7	20,4	14,6	53.4	46.9

Source: RHFS, UNFPA–Angola, 1999/2000

It corresponds to the Province of Zaire the lowest mean value: less than 4 children. The desire for having additional children is more intense in Huila and Benguela, which is evidenced by the high proportion of women that would want to have at least four additional children (80% approximately). In the provinces of Malange and Zaire, this proportion would be less than a third.

*b) Male Expectancy about family size.*

About a third of the men expects to have the number of children that “ *shall be born*” without bothering about limitation issues. This expectancy, on the one side, does not depend on the interviewee’s age, but varies according to provinces: the largest proportion is located in Malange, where almost 60% of displaced men answer this way. The will of avoiding future children was manifested by only 13% of the interviewed men being slightly higher among the adults (17%). At the provincial level, with exception of Zaire, the desire for having more children is virtually universal.

The men’s average number of additional desired children is 4,3 and the highest number corresponds to youngsters, which is expected, once the probability of having completed the ideal family size is larger among the population at older ages.

When considering that the average number of CEB declared by men is superior to 4, the ideal family size may be estimated by adding this number to the number of additional desired

children. Thus, the ideal family size goes close to nine children (See table 4). This rationality applied to the youngster's answer, ends up to an ideal number of 6.5 children approximately.

In synthesis, in this context of high fertility, the results suggest that the level would hardly decrease in the short term. The desire broadly disseminated of a high number of children is present between men and women - although, in this case, answers were from just pregnant women<sup>9</sup>. In the case of men, the ideal family size is relatively smaller among the youngsters; this fact might be interpreted as the embryonic demand for family planning and consequent possibilities of initial fertility decrease. In that sense, the process of demand for family planning would be probably easier to implement in the province of Zaire, than in the other ones. The ideal family size among the youngsters of this province is the smallest, and, it is here where the will of not having more children was stated. It also corresponds to this province the smallest number of desired children for pregnant women.

**Table 4**  
**Total and provinces - a) Pregnant women by number of additional desired children and b) Males by children ever born (CEB) and number of additional children desired**

Provinces	a) Pregnant women by number of additional desired children	Males by age and children's average					
		Up to age 25			Aged 25 or more		
		CEB	Additional desired children	Total	CEB	Additional desired children	Total
<b>Total</b>	<b>4.70</b>	<b>1.9</b>	<b>4.6</b>	<b>6.5</b>	<b>4.5</b>	<b>4.2</b>	<b>8.7</b>
Huila	5.00	1.7	4.4	6.1	5.4	3.4	8.8
Benguela	5.18	1.9	4.4	6.3	4.6	3.9	8.5
Malange	4.76	2.2	5.1	7.3	3.4	5.0	7.4
Zaire	3.67	1.5	4.2	5.7	4.5	4.3	8.8

Source: RHFS, UNFPA-Angola, 1999/2000

c) *Male and female attitudes toward high fertility trends*

Previous findings about reproductive preferences indicate, with few doubts, that most of the population perceives as natural the continuity of having (more) children. It is a behaviour expressed clear and almost universally in the survey answers, either as affirmative actions or as passive attitudes. Both the significant proportion of women that affirm not to have autonomy to decide about timing of the next pregnancy and the significant proportion of men that accept the children that “*shall be born*” are indicative of this natural fertility. Focus groups however, at the same time that confirm previous findings allude to an ambiguous desire for fertility control. See the following four talks:

As for natural fertility:

<sup>9</sup> Since the desired number of children is also extremely high among pregnant women, there is no reason for excluding non-pregnant women from this inference.

Women: “...na nossa família, tem que completar 15 filhos; assim, ainda me falta muitos”

*[My family has to round 15 children; I still must deliver most of them].*

Men: ... O pensamento de ter 30 filhos está presente. Está claro, eu penso aumentar mas não penso da senhora. É possível que na barriga da mulher já acabou. Mas o pensamento de ter muitos filhos está presente. O marido pode ter cabelo branco, mas os filhos têm que vir sempre”.

*[The thought of having 30 children is in on my mind. Of course I want them and I do not mind about the woman –partner– It is possible that her belly is worn out already, but the thought is on my mind. The husband might have white hair, but children must be born”*

As for concern about fertility control:

Women:..“Estou mesmo dentro da casa do meu marido, não imagino de ter mais ...  
...quero só 2 porque o sofrimento é muito ...”.

*[I'm in my husband family house, I can not imagine of having more –children– I only want two, because I suffered so much...*

Men: “Na minha vez a saúde não me permite. Agora, no novo acampamento não quero mais filhos e ainda agora de certeza, como Deus continua a me dar filhos, vou recebê-los. Já não queria mais, pois os filhos que estão a nascer estão a passar o mesmo caminho –da morte.”

*[Because of my health I can not bear –children–. Now, settled in the camp, do not want more children, I'm sure, however that God continue to give me children, they are wellcome. I rather not, since once they ar born, they are on the way (to dead)]*

#### 4. 2. 2 Knowledge and use of contraception among men and women

Table 5 about knowledge of contraceptive methods shows that less than 13% of women know some method for avoiding pregnancy without relevant differences by age or provinces. In this small universe (detailed is not shown), they mention, on average, almost two known methods, again, without relevant differences by age or provinces. The most mentioned methods are injections, condoms and pill (each method with approximately 20% of responses). The calendar method was less mentioned (11%). Regarding the traditional methods, an important proportion of 14% was registered. Related to males, 30% of the interviewed know some contraceptive method, proportion that, even, relatively low, is 2,5 times larger than in the case of women. Considering that women are basically the potential users of contraceptive methods, one may infer that in this population women's control about her reproduction is clearly limited.

Among provinces, men from Zaire would have better knowledge, and still better among th adults, where the proportion is of almost 50%. The difference for provinces is coherent with th fertility estimates found. Thus an important association between fertility levels and knowledge of contraceptive methods among men is verified.

**Table 5**  
**Male and Female Population: Contraceptive knowledge by sex and age groups and according to provinces for males**

Province	Total (absolute figures)	Age groups (%)		
		Total	Up to age 25	25 or more
Male	178	30.0	23.9	32.2
Female	89	12.7	12.5	12.6
Males by province				
Huila	32	24.4	17.1	27.1
Benguela	48	31.2	36.7	29.8
Malange	39	23.5	25.9	22.2
Zaire	59	41.5	15.6	49.1

Source: RHFS, FNUAP-Angola, 2000

From those answering knowledge of some method, half (178 men) refers, on average, little more than 2 methods (Data not shown). Remember that among less developed countries, the average of know methods is above 10<sup>10</sup>. Pill and calendar are the more mentioned methods (together they add almost 40% of the cases) being followed the injection. Lastly, according to age, the pill is the more mentioned method among the youngsters.

An indication of lack of knowledge about contraception methods, is the myth of the breast-feeding to be considered a contraceptive method in 4% of the cases, being relatively higher among youngsters. Abortion is also mentioned as thus.

Regarding the use of methods, there were identified 35 women practising contraception (5% approximately), indicating the excessively low contraceptive prevalence. In this small universe of users, a third uses the calendar, with no differences by age. In smaller proportion appears the injection, being more accentuated among women aged 25 or more. The use of the condom, with the low frequency of 10% seems to be more frequent among youngsters.

Regarding men, contraception practice is about 15%. Noticed, however that the prevalence concentrates in Zaire, where the proportion is 36% (with higher values for adults). In the other provinces the percentage is lower than 10%.

Finally, both knowledge and use of contraception among men and women practising contraception indicate reproductive patterns behaviour largely differentiated by gender.

### 4.2.3 Demand for contraception

<sup>10</sup> African countries that participate in the Demographic and Health Survey project, present an average above four known methods (Curtis and Neitzel, 1996).

"Unmet need" of contraceptive methods is defined here as the women's proportion that would like to use some method but they don't use due to lack of knowledge, inaccessibility or unavailability of services of reproductive health.

From 89 women knowing any contraceptive method 46 declared non-use of them. About 1/3 out of these 46 women, constitutes "unmet need"; the remaining 2/3 was pregnant, wanted to become pregnant or did not have a partner. Among the reasons given for not using contraception, difficulty and/or lack of information for obtaining them were common responses. Answers mentioning health side effects were also recorded.

Among the men there would be, basically two reasons for not using contraception: (a) intention of having a numerous family and/or not to be interested in family planning; and (b) lack of knowledge about the subject. Both of them add about 80% of the reasons for not practising contraception, regardless of the province. (See Table 6). Remarkably the lack of knowledge is important among youngster, where the proportion reaches 41%.

**Table 6**  
**Total and provinces - Male Population: Reasons for not using contraception**

Province	Total		Wants large family and/or without interest for famil planning	Does not know	Social Pressure	Does not allow the wife to use contraception
	Absolute	Relative				
<b>Total</b>	<b>425</b>	<b>100,0</b>	<b>39,6</b>	<b>36,0</b>	<b>9,5</b>	<b>14,7</b>
Huila	83	100,0	47,1	34,9	4,8	13,3
Benguela	145	100,0	35,8	37,3	10,5	16,4
Malange	134	100,0	39,7	24,6	4,0	31,7
Zaire	132	100,0	37,2	25,6	15,4	21,8

Source: RHFS, FNUAP-Angola, 2000

There are other reasons of relative importance that vary among the provinces, as it is the case of ‘the religion’ or ‘the community’ that are important in Zaire, but they are not in Malange. quite important reason for not practising contraception in Malange is the husband’s attitude of not consenting contraception use by the wife: it almost constitutes a third of the reasons. To a lesser extent but impressive in any case, it is also the case of Zaire.

The "potential demand" for contraceptive methods is defined in this study as the women's proportion that declared at the time of the survey non use of contraception but it would like do so in the future. Related to men it is considered “potential demand” all those with favourable opinion regarding the methods although they are not using them.

Regarding to the question about intention of future contraception use about 1/3 of women answered that they would like to practice it in the future. Without significant differences by age, figures point out higher proportions among younger women.

The men's opinion concerning the contraceptive methods can be classified, according to Table 7 in two large groups: On the one side, potential users: those that believe methods are important and prevent STD, whose proportion is 40%. This figure correlates with women's answers: the potential demand equivalent to the women's proportion that would like to use some contraceptive method in the future is 36%, with slightly higher values for the youngest.

On the other side, the resistant to use contraception: 60%. They do not agree in using or do not find them important (52,4%); Also they say that it is bad for health, are inconvenient during intercourse, etc. (7,6%). This latter category is approximately what we know as “unmet need”

With important variations, the data reveal that Benguela would be the province where there would be a large number of potential users, while in Malange the men seem to have relatively more resistance to contraceptive practices.

Synthesising, among the displaced women the knowledge and use of contraceptive methods are very reduced; lack of information and inaccessibility to services of reproductive health are factors that would largely explain this low prevalence. It must be added to this explanation, the strong desire of a large family size. Among males the knowledge about contraception is also low. Besides, it is important the proportion of those with resistance to use of contraceptive methods, backed by the desire of having a large family size or “*the children that the ‘God-will’ determine*”.

**Table 7**  
**Total and provinces: Male's opinion about contraceptive methods**

Province	Total	Are important and/or avoids DST	Does not agree to use or they are not important	Other unfavorable opinions
<b>Total</b>	<b>100,0</b>	<b>39,9</b>	<b>52,4</b>	<b>7,6</b>
Huila	100,0	43,4	50,6	6,0
Benguela	100,0	51,0	46,2	2,8
Malange	100,0	27,6	60,4	11,9
Zaire	100,0	37,9	52,3	9,9

Source: RHFS, FNUAP-Angola, 2000

Results from focal groups indicate that the low prevalence of modern methods and/or effective is related to cultural faiths and practices as for instance the use of warm stones. Breast-feeding, far to be considered a method used voluntary or rationally, is faced as an impediment for intercourse. Abstinence is also a frequent practice in cases of high parity, when woman is put aside due to extreme fragility for undergoing intercourse, regardless of any perspective of becoming pregnant.

#### **4. 2. 4 Abortion and unwanted pregnancy**

Among the elements that could suggest a pressure to reduce the fertility among the displaced, it could be considered the unwanted pregnancies and the incidence of abortion. Regarding the former, a significant proportion of women declare to have heard of unwanted pregnancies (20% approximately), and in their opinion, most of those unwanted pregnancies were attempted to be interrupted (75%). With exception of Zaire, where this knowledge is more accentuated among the adult women, there would not be significant differences by age. Malange presents the highest proportion.

Additionally and notwithstanding, men and women in the qualitative survey were extremely critical and moralists against any attitude for interruption of pregnancies; also the focal groups reveal that younger women may practice induced abortion more often than the rest. For women aged 45 years or more, induced abortion is recognised as extremely negative and the pressure of cultural and religious background seems to be an important factor to inhibit induced abortion.

On the one side, the perception of affirmative attitudes for fertility control is configured once there is accepted that younger women do have induced abortions; on the other side, there is, still, the pressure of older generations that, in any case, are not contributing anymore to the reproduction process.

Additional to the matter of ‘having heard of someone who practised abortion’, the survey also questioned about abortion as a personal experience. Then, among the displaced women, abortion prevalence seems to be extremely high. About 25% of the valid cases refer to women that would have had aborted. Among women at the end of the reproductive period, one out of three would have aborted. It corresponds to Malange, the higher proportion, and for adult ones, the proportion goes up to more than 30%.

This type of information suffers very often from lack of reliability, in this case however, comparison of answers by men and women indicate somehow they are reliable. Table 8 shows that proportion according to sex of the respondent, generally speaking, are similar: about 24% of women (or wives’ men) would have experienced abortion<sup>11</sup>.

As in previous situations, this proportion hides variations for provinces, mainly when related to male answers. In fact, considering the variations due to the low number of cases, in Huila, more than 40% of the men admit that their wives had aborted. This proportion decreases to 14.4% in Zaire.

As for women that had aborted, two thirds of them declared that they had just one; as average these women had 1,5 abortions. Spontaneous haemorrhage or disease would have caused most of the abortions. There were identified three women having miscarriages a consequence of aggressions, and eight due to unwanted pregnancies.

As in previous case, the male answers are, in general, similar to the given by women. The exception is on the category “Other” that includes haemorrhages caused by aggressions. It is



important to emphasise that women declare these causes more frequently than men do. Furthermore, one may deduce from these figures that men prefer to declare accidents rather than aggressions (by him?) as a cause of abortion.

**Table 8**  
**Male and Female Population – Abortion incidence**

a) Women that ever had abortion and Males declaring that their wife ever had abortion (%)

Province	Female				Males			
	Total (Absolute figures)	Total %	Up to age 25	25 or more	Total (Absolute figures)	Total %	Up to age 25	25 or more
<b>Total</b>	<b>165</b>	<b>24.3</b>	<b>14.3</b>	<b>29.9</b>	<b>135</b>	<b>24.2</b>	<b>9.0</b>	<b>29.1</b>
Huila	21	18.6	10.9	25.9	45	41.3	51.8	7.7
Benguela	46	24.7	16.9	30.3	38	25.9	13.6	28.0
Malange	52	29.1	18.3	34.5	32	19.8	7.3	26.2
Zaire	46	22.9	9.6	27.5	20	14.4	15.7	9.7

b) Reasons for abortion according female and male answers

Sex of interviewed	Total (Absolute figures)	Reasons for abortion				
		Total (%)	Undesired pregnancy	spontaneous bleeding	Accident	Others (disease, aggression)
Male	117	100,0	5,1	60,7	11,1	23,1
Female	154	100,0	5,2	55,2	7,8	31,8

**Women's age**

Up to age 25	34	100,0	5,9	58,8	2,9	32,4
25 or more	120	100,0	5,0	54,2	9,2	31,6

Source: RHFS, UNFPA-Angola, 1999/2000

Summarising, the prevalence of the abortion is relatively high among these women, ¼ would have had some abortion in her life, this fact is corroborated by the men's answers. Violence seems to be an important cause. There is clear perception about existence of unwanted and interrupted pregnancies. Considering that –even in poor contexts– the incidence of spontaneous abortions and foetal losses should be less than 10–15% of total pregnancies (Morillo, 1997; Pebley, 1985), and the common constraints to abortion-related questions –whether or not spontaneous– the numbers of abortions declared can support the hypothesis of a high prevalence of induced abortions.

<sup>11</sup> Proportions do not coincide by age and sex of the respondent because husband and wife do not usually have same ages. To a lesser extent, this is valid for the provinces, once answers are related to the past, when abortion may have occurred in different places of residence.

This hypothesis must be very better supported and we believe, it justifies further research, being a real situation, it would demand a special and immediate attention from the corresponding authorities. There is no doubt about the serious consequences to the women’s reproductive health and their general well being that unsafe induced/spontaneous abortion causes. If this is true in any population, it is true also that consequences of unsafe abortion into such vulnerable population as the displaced, are far worse.

Finally, it is also clear that this high incidence is also an indicative of voluntarily–unhealthy–unsafe fertility control or, in other words, a dangerous unsatisfied demand for contraceptive methods.

## **5 Mortality**

This item presents one of the most direct effects of the war: the dead. In the first place, indirect mortality measures are discussed, then some figures about dead and missing relatives are presented.

### **5.1 Mortality Levels**

Estimates about mortality were obtained indirectly through information about CEB and children survivorship. Results present practically without doubts the high mortality levels, overcoming general averages for the country. The mortality measures that were possible to obtain with this information are summarised in Table 9 and probabilities of dying are presented by province in decreasing order.

Before considering the mortality levels obtained, two methodological considerations are necessary. Firstly, in order to minimise effects of random variations due to the reduced number of events, in some cases, the estimates were derived using two mortality models that, we believe, reflect quite well the situation of the surveyed population. The models were the West family from the Coale and Demeny Life Tables Model (Coale and Demeny, 1983) and the Brass’s General Model, based on African data of the sixties and seventies (Brass, 1978). Secondly, it should be stated that the mortality estimates, here presented, correspond, due to the method, to a period of approximately two/three years before the data collection, that was, when most of this population was highly exposed to the war chaos, which became worse at the beginning of 1998.

An overview of the results indicates, on the one side, looking at the applied models, that they reproduce values, in general, very similar, which, in a way, gives reliability to the collected information. On the other side, looking at the obtained levels, although they are high, it looks like there are two subsets: Zaire and Huila with high mortality levels and Malange and Benguela with extremely high mortality levels.

Infant mortality –measured in this case, through the probability of dying before the first year of life and regardless of the model used– is located well above the warning value of 200 per

thousand births. More precisely, for the total population, Infant Mortality is between 271 and 276 per thousand live births.

**Table 9**  
**Mortality measures (\*) for the total displaced population (both sexes) and by provinces**

Province	Life Table Model employed:					
	a) West (Coale & Demeny)			b) General (Brass)		
	Probability of dying among ages <sup>(**)</sup> :		Life Expectanc (In years )	Probability of dying among ages <sup>(**)</sup> :		Life Expectanc (In years )
	Ages 0 - 1	Ages 1 – 5		Ages 0 - 1	Ages 1 – 5	
<b>Total</b>	<b>271.4</b>	<b>130</b>	<b>41.1</b>	<b>276.5</b>	<b>171</b>	<b>35.2</b>
Zaire	205.7	94.5	43.9	209.3	119.5	40.8
Huila	223.1	101.9	42.2	224.5	123.5	39.6
Malange	256.6	151.6	32.9	319.7	210.3	27.6
Benguela	337.5	168.5	30.2	345.5	218.6	26.8

(\*) Average values from answers of women aged 20 – 30 about CEB and surviving children

(\*\*) In thousands

Source: RHFS, UNFPA-Angola, 1999/2000

Simplifying, among the displaced approximately three children out of ten die before completing the first year of life. The country average estimated using data from the national survey MICS 1996 is 159 per thousand. For comparison purposes, notice that in countries with medical technology and reasonable social development, the equivalent probability is less than 10 per thousand<sup>12</sup>.

It corresponds to Benguela the highest probability of dying for children (above 300 per thousand) and the smallest – though above 200 per thousand– to Zaire.

Equally high is the mortality between 1 and 5 years. After the barrier of the first year of life is succeeded, where the risk of dying is the largest, a child's probability within ages one and five years old is between 130 and 170 per thousand. For Malange and Benguela, the provinces of larger mortality in childhood, this risk would be, in any way above 150 per thousand.

In terms of life expectancy at birth ( $e_0$ ) measure of easier comparison, the values go to equally extreme position. Reminding that in 2000 there were populations with  $e_0$  close to 80 years (United Nations, 2000), in the surveyed population, results indicate that life expectancy would oscillate among 35 to 41 years, if present risks are maintained.

<sup>12</sup> This is the case of Cuba for the period 1995-2000, several countries in Oceania and most countries in North Europe. (United Nations, 2001)

There are significant differences with national average, which over the nineties was estimated between 40 and 45 years.

As mentioned before, the worsening of mortality, more than a direct war consequence it is, also, product of the social and economical disorder that reaches everybody but above all the displaced population. The condition of extreme poverty typical from the displaced – concerning nutrition, health, safety– affects proportionally more the children, since in a civil war situations, the first resources to be deviated, are precisely, those would had benefit them. (Kiros and Hogan, 2000).

Finally in provinces of higher mortality, the  $e_0$  is around 26-30 years; lower values than those estimated for the poorest countries of the continent (Sierra Leona, Mozambique or Malawi, are close of a  $e_0$  around 40 years. United Nations, 2000).

Summarising, the stress of the war that the displaced has endured brought about without doubt the lowest probabilities of human survival. It shall be remarked, in addition that these levels, although correspond to the war displaced population, they shall not vary from the rest of country. In fact, considering that the displaced represent about 1/3 of the total population and the effects of war on the whole territory, these mortality levels have certainly worsened th national levels.

## 5.2 Dead and missing relatives during the wa

To have a notion of losses in human lives caused by the war in Angola since 1975 in th displaced interviewee's family, a question about the number of relative's dead or missed as a direct consequence of the war, was included. There are not included therefore, indirect war effects like starvation–related deaths (as diarrhoea, for instance) lack of medicines, ‘voluntarily’ migration leavings, etc.

There are no references about systematic collection of this data in similar surveys, and due to th lack of experience; it certainly suffers from methodological biases. We are aware, particularly, of errors due to lack of memory for reporting deaths happened in such a long period (24 years), fear of revenge and/or retaliations, etc.

Related to deaths, 771 interviewed declared 1.144 deaths of relatives as direct consequence of the war, which averages almost 1,5 dead relatives per family. Table 10 – in order of importance– shows that most of dead relatives refer to the father, siblings, other relatives, mother and sisters. Almost everybody refer parents and/or siblings, which reflects somehow th impressive process of family disintegration that the displaced had suffered due to the military conflicts.

Regarding relatives, 401 interviewed declared 454 missing relatives, or about 1,1. Most of the cases concentrate on items ‘other relatives’ and ‘brothers’. Sisters are also important proportions of missing relatives. The significant proportion of missing siblings pinpoints even more forced displacements if it is assumed that, on average, siblings have the same age that the respondent, i.

e., most of them are at economically/reproductive ages. Apart from –highly possible– being actual deaths, the proportion may indicate further family emigration toward ignored places considering that at those ages, sisters and brothers may have already partners and children.

**Table 10**  
**Dead or missing relatives as direct consequence of war (Multiple answers)**

Relative	Dead		Missing	
	Reported Cases	Relative distribution (%) <sup>*</sup>	Reported Cases	Relative distribution (%) <sup>*</sup>
<b>Total</b>	<b>1144</b>	<b>148,4</b>	<b>454</b>	<b>113,2</b>
Fathe	285	37,0	37	9,2
Mother	178	23,1	28	7,0
Brother	232	30,1	124	30,9
Sister	178	23,1	83	20,7
Spouse	35	4,5	10	2,5
Children	7	0,9	4	1,0
Other relatives	229	29,7	168	41,9
None/ Unknown	0	0	370	
Interviewed			771	

<sup>(\*)</sup>Total above 100% due to multiple answers. Proportion exclusive of ‘None/ Unknown’ answers  
 Source: RHFS, UNFPA-Angola, 1999/2000

In short, the displaced have, on average, around two died or missing relatives, most of the times they are talking about one or two parents. Which means, they have lost vital part of the familiar nucleus. In spite of methodological deficiencies these results reveal the damage that war causes in defenceless population and confirm the family breakdown provoked by the war conflict. During the focal groups, the suffering that this breakdown causes, at the physic and psychological level is clearly expressed. Their talks are important for better understanding of the cold figures:

- “...as pessoas que não têm marido, o sofrimento é demais; as pessoas não dormem.... quando vem em casa é só chorar, só chorar, fica doente a tensão, a tensão, ...; a pessoa se tem comida, bocado de roupa o coração fica no lugar, normal só ainda porque aqui não tem guerra”.  
 [...women does not have partners, suffering is unbearable; one does not get sleep ... at home, it just crying, just crying, there is sickness, stress, stress...: if you have food, a bit of cloth, then the heart calm down, but this is a normal place just because war still has not coming...]

- “*Tenho sentimento, raiva e rancor ao lembrar o que vivi antes e o que vivo agora*”  
[I have feelings, anger and hate when I remember what I lived and what I live]
- “*Muita famílias têm a mãe como chefe e as filhas adolescentes estão fora do acampamentos e trabalham nas cidades como domésticas*”  
[The mother is the head of the family in most cases and the teenager daughters are out of the camps, and working in the cities, as maids]

## 6. Some concluding remarks

It is very difficult to withdraw any conclusion about the demography of the displaced population turning aside other conspicuous elements as famine and environmental degradation that more often than not come together with war. Nevertheless, since countless warning issues were revealed by the survey, this item recapitulates main findings intending the most possible objectiveness one may have in these situations.

Thus, related to the reliability in the first place, we believe that despite difficulties for implementation of the project about the displaced and war refugees in Angola, particularly those related to the fieldwork, dataset showed consistent results.

Regarding to migration flows, there is no doubt that they are direct consequence of the war intensity; flows and re-flows went up and down as the half peace/half war situation was on the way. Quantitative data and focus groups information reveal frustrated but recurrent intentions to go back to original places of residence. Whether or not peace is about coming, resettlement of the displaced that are eminently rural is a critical issue. Besides, another remark is the number years already settled in camps that are meant to be transitory. The displaced are resistant to make long distance movements remaining in the same province; more often they flee from village to village before the final movement to the capital district where, in the condition of displaced may remain for years. The average period found is about three years, there are displaced, however, staying for more than five/seven years in the camp, living in the most precarious ‘transitory’ life conditions.

Reproductive behaviour aims to the highest possible number of children, which means extremely short birth intervals and maternal depletion to begin with. There are indeed signals of some desire for fertility control among both men and women but social and cultural value seems to overcome them. Cultural attitudes are obstacles even for preventive health services as prenatal care, which may be avoided for fear of abnormal foetus growth. Yet, woman status remains as one of the main obstacles for family planning; gender relations are extremely unfavourable to them as Fonseca *et alii* (2001) demonstrate. In our study, proportion of women unable to decide whether or not to

conceive, lack of knowledge about contraception and miscarriages caused by accidents and violence are evidences of null female empowerment related their bodies. As for the impact of women submission in the fertility levels, following talking by men are far enough:

- *“A mulher não pensa, você é que inicia. Eu é que sinto os desejos e estou doente. Tenho vontade, pronto!. - Como estou com dores tenho que te chatear e tens que me dar o que eu quero, se não dá te amarro, eu sou homem”*  
*[The woman does not think. You are the one of the initiative. It is me who has desire and becomes sick. I want (to have intercourse), that's it! . If I'm painful (exited about intercourse), I may bother you, but you must give me what I want. Otherwise I'll tie you. I'm the man”]*
- *“Muitas das vezes você esta dormir você quando acorda, não tem mais conversa, é só subir”*  
*[Most of the times you are sleeping and suddenly you wake up. There is no chat at all. It is just a question of climbing into”]*

Related to mortality, life expectancy around 35-40 years and Infant Mortality over 250 per thousand are auto–explicative. The extra critical issue here is that as war conflict has intensified after data collection was done, life conditions have probably worsened and so mortality levels. The sentence applies not just to the displaced but to whole country, since, as mentioned, displaced and refugees account for over 30% of the total population.

Finally, it is clear that there is so much to be done from the humanitarian point of view. The starting point is the end of armed conflicts and rebuilding of the country. Limiting our scope to the demographic research side, some of the aspects that need deep work are :

- Possibilities of further resettlement and identification of the more convenient areas for the displaced.
- Design of programmes to facilitate and stimulate access to health services
- Strategies for safe implementation of men and women reproductive preferences and changing women status without outraging cultural values.

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## ANNEXES

**Table A 1**  
**Survey on Reproductive Health and Family Life among displaced people**  
**Sample Composition by age and sex distribution**  
**(Absolute and relative figures)**

Age groups	Absolute Numbers			Relative Distribution (%)		
	Total	Male	Female	Total	Male	Female
<b>Total</b>	<b>1421</b>	<b>645</b>	<b>776</b>	<b>100,0</b>	<b>45,4</b>	<b>54,6</b>
14	28	14	14	2,0	1,0	1,0
15-19	206	92	114	14,5	6,5	8,0
20-24	211	64	147	14,8	4,5	10,3
25-29	252	99	153	17,7	7,0	10,8
30-34	260	128	132	18,3	9,0	9,3
35-39	172	81	91	12,1	5,7	6,4
40-44	99	44	55	7,0	3,1	3,9
45-49	103	61	42	7,2	4,3	3,0
50-54	85	61	24	6,0	4,3	1,7
Unknown	5	1	4	0,4	0,1	0,3

Source: RHFS, UNFPA-Angola, 1999/2000

**Figure 4**

Municipal district of current residence and residence In October 1992 (Fixed data)

Municipal district of residence in Oct/92	Current municipal district of residence									
	Lubango	Chibia	Matala	Benguela	Lobito	Bahia farta	Malange	Cacuso	Mbanza Congo	Vungue
Lubango	25.4									
Caluquembe	26.9									
Baia Farta	22.4									
Cacond	13.4									
Others	37.3									
Chibia		2.8								
Cacond		29.2								
Chongoroi		18.1								
Lubango		9.0								
Others		43.8								
Matala			35.9							
Quilenges			51.3							
Chicomba			5.1							
Chibia			5.1							
Others			38.5							
Benguela				5.4						
Gand				49.7						
Chongoroi				23.8						
Cubal				4.8						
Others				21.8						
Lobito					23.2					
Londumbali					22.6					
Huambo					13.5					
Balombo					6.5					
Others					34.2					
Baia Farta						10.0				
Chongoroi						62.0				
Cubal						8.0				
Caimbambo						6.0				
Others						24.0				
Malang							1.8			
Quipung							21.4			
Cala							17.0			
Londumbali							11.4			
Others							50.2			
Cacuso								0.0		
Quipung								33.33		
Cala								26.32		
Cubal								14.04		
Others								26.32		
Mbanza Cong									0.4	
Vungue									54.84	
Kot									34.68	
Suing									2.42	
Others									1.21	
Vung										100.0

Source: RHFS, UNFPA-Angola, 1999/2000

**Figure 5**

Municipal district of current residence and residence In December 1998 (Fixed data)

Municipal district in Dec/98	Lubango	Chibia	Matala	Benguela	Lobito	Bahia farta	Malange	Cacuso	Banza Con	Vunge
Lubango	74.7									
Baia Farta	8.4									
Caconda	7.2									
Caluquer	7.2									
Others	2.4									
Chibia		52.1								
Lubango		19.9								
Caconda		6.8								
Chicuma		6.2								
Others		15.1								
Matala			48.7							
Lubango			25.6							
Matala			15.4							
Chibia			5.1							
Others			5.1							
Benguela				46.3						
Ganda				41.5						
Chongoroi				2.0						
Cubal				2.0						
Others				8.2						
Lobito					65.2					
Londumbali					8.9					
Huambo					6.3					
Balombo					3.2					
Others					16.5					
Baia Farta						28.0				
Chongoroi						34.0				
Benguela						22.0				
Lobito						6.0				
Others						38.0				
Malange							0.9			
Cala							70.4			
Quipungo							5.7			
Londumbali							5.2			
Others							17.8			
Cacuso								0.0		
Cala								41.07		
Cubal								30.36		
Quipungo								17.86		
Others								10.71		
Mbanza Congo									0.4	
Vunge									53.28	
Kota									40.54	
Karibu									0.77	
Others									5.02	
Vunge										100.0

Source: RHFS, UNFPA-Angola, 1999/2000

**Table A 2**  
**Women by age and Children ever born (total, born during the last 12 months and dead)**

Age group	Women	CEB		
		Total	Born during the last 12 months	Dead
<b>Total</b>	<b>733</b>	<b>2996</b>	<b>276</b>	<b>930</b>
15-19	114	62	27	20
20-24	147	316	75	87
25-29	153	566	67	161
30-34	132	761	64	218
35-39	91	623	33	218
40-44	54	363	8	115
45-49	42	305	2	111

Source: RHFS, UNFPA-Angola, 1999/2000

**Table A 3**  
**Average Children Ever Born (CEB) by age of women - Total population and provinces**

Age Group	a) Total population			b) By provinces			
	Total	Does not live with the mother	Death	Huila	Benguela	Malange	Zaire
15-19	0,5	0,0	0,2	0,1	0,6	1,0	0,3
20-24	2,2	0,1	0,6	2,2	2,2	2,1	2,0
25-29	3,7	0,5	1,1	4,4	4,1	3,9	2,9
30-34	5,7	0,7	1,7	6,2	6,0	6,4	4,8
35-39	6,8	1,1	2,4	6,7	7,3	7,0	6,3
40-44	6,6	1,2	2,1	6,7	7,6	6,4	6,0
<b>45-49</b>	<b>7,3</b>	<b>1,5</b>	<b>2,6</b>	<b>8,2</b>	<b>9,1</b>	<b>7,4</b>	<b>5,9</b>

Source: RHFS, UNFPA-Angola, 1999/2000

**Table A 4**  
**Expectancy about getting pregnant and period to do so - by age and provinces**

Province	TOTAL		Expects to get pregnant				Does not want to get pregnant	
			Sub Total	Period				
				Imme- diately	Next year	After one year		Can not decide
Total	<b>668</b>	<b>347</b>	64	73	97	113	<b>322</b>	
	100.0	51.8	18.4	21,0	28,0	32.6	48.2	
By age								
Up to age 25	242	100.0	59.1	19.2	20,5	27,4	32,9	40.9
25 or more	426	100.0	50.0	17.9	21,4	28,4	32.3	49.4
Provinces								
Huila	131	100.0	45.8	21.7	15,0	35,0	28,3	54.2
Benguela	173	100.0	48.0	25.3	21,7	30,1	22.9	52.0
Malange	172	100.0	58.7	17.8	24,8	35,6	21.8	41.3
Zaire	192	100.0	53.1	11.7	20,4	14,6	53.4	46.9

Source: RHFS, UNFPA–Angola, 1999/2000

**Table A 5**  
**Male and Female Population: Contraceptive knowledge by sex and age**

Age Group	Absolute figures	Males			Female		
		Total	Yes	Not	Total	Yes	Not
Total	<b>1296</b>	<b>593</b>	<b>178</b>	<b>415</b>	<b>703</b>	<b>89</b>	<b>614</b>
		<b>100,0</b>	<b>30,0</b>	<b>70,0</b>	<b>100,0</b>	<b>12,7</b>	<b>87,3</b>
Up to age 25	415	100,0	23,9	76,1	100,0	12,7	87,3
25 or more	881	100,0	32,2	67,8	100,0	12,6	87,4

Source: RHFS, UNFPA–Angola, 1999/2000